

## General

### Guideline Title

Ocriplasmin for treating vitreomacular traction.

### Bibliographic Source(s)

National Institute for Health and Care Excellence (NICE). Ocriplasmin for treating vitreomacular traction. London (UK): National Institute for Health and Care Excellence (NICE); 2013 Oct. 52 p. (Technology appraisal guidance; no. 297).

### Guideline Status

This is the current release of the guideline.

## Recommendations

### Major Recommendations

Ocriplasmin is recommended as an option for treating vitreomacular traction (VMT) in adults, only if:

- An epiretinal membrane (ERM) is not present and
- They have a stage II full-thickness macular hole (FTMH) with a diameter of 400 micrometres or less and/or
- They have severe symptoms

### Clinical Algorithm(s)

None provided

## Scope

### Disease/Condition(s)

Vitreomacular traction (VMT)

### Guideline Category

Assessment of Therapeutic Effectiveness

Treatment

## Clinical Specialty

Ophthalmology

## Intended Users

Physicians

## Guideline Objective(s)

To evaluate the clinical effectiveness and cost-effectiveness of ocriplasmin for treating vitreomacular traction (VMT)

## Target Population

Adults with vitreomacular traction (VMT) without an epiretinal membrane (ERM) and when associated with stage II macular hole (MH) of diameter less than or equal to 400 microns and/or severe symptoms

## Interventions and Practices Considered

Ocriplasmin

## Major Outcomes Considered

- Clinical effectiveness
  - Proportion of patients with non-surgical resolution of vitreomacular adhesion (VMA) at day 28
  - Proportion of patients with posterior vitreous detachment (PVD) at day 28
  - Proportion of patients with full thickness macular hole (FTMH) closure
  - Change in visual acuity
  - Proportion of patients who had vitrectomy by month 6
  - Adverse events of treatment
  - Health-related quality of life (HRQoL)
- Cost-effectiveness

## Methodology

### Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

### Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Care Excellence (NICE) commissioned an independent academic centre to perform an assessment of the manufacturer's submission on the technology considered in this appraisal and prepare an Evidence Review Group (ERG). The ERG report for this technology appraisal was prepared by the BMJ Technology Assessment Group (BMJ-TAG) (see the "Availability of Companion Documents" field).

## Clinical Effectiveness

### Searches

The manufacturer searched MEDLINE, MEDLINE (R) In-process, EMBASE, The Cochrane Library, National Health Service (NHS) Economic Evaluation Database, Database of Abstracts of Reviews of Effectiveness (DARE), Health Technology Assessment (HTA) database, and [www.hta.ac.uk/erg/index.asp](http://www.hta.ac.uk/erg/index.asp) for published literature. The searches were conducted on 10 September 2012 and no restrictions were placed on the date of the published studies. The proceedings of the American Academy of Ophthalmology and The Association for Research in Vision and Ophthalmology (ARVO) international conferences (with time limit set to most recent three years), and clinical trial registry (clinicaltrials.gov) were searched for additional relevant studies, as were the reference lists of included studies.

The manufacturer grouped search terms by disease, therapies, current treatment practice and unmet needs, then applied a search filter for current treatment practice and unmet needs combined with disease terms, and a search filter for clinical studies combined with disease terms and therapy related terms. The ERG considers that the disease terms were comprehensive and likely to have identified the population of interest. The search term "pars plana vitrectomy" was noted as a key omission in the group of 'therapies' terms. Due to time constraints, the ERG was unable to replicate the manufacturer's search and appraisal of identified abstracts for all databases.

Given the broad range of study types that would be required to address all of the research questions posed by the manufacturer, the ERG believes the clinical study search filter might not have retrieved all relevant studies; the filter excluded qualitative studies which might have been used to inform the questions on social impact. In addition, the search did not span social science databases (such as PsycINFO) which might have elicited studies relevant to the research questions on patient preferences and social impact. However, the ERG notes that these questions were not used to inform the review of clinical effectiveness evidence.

In summary, the manufacturer conducted a broad literature search of the key electronic databases, including MEDLINE, EMBASE and The Cochrane Library, for randomised controlled trial (RCT) and non-RCT evidence relevant to decision problem and the context of the decision problem. The ERG considers that the manufacturer is likely to have identified all RCT evidence relevant to the decision problem that is the focus of this single technology appraisal (STA).

### Inclusion Criteria

The manufacturer states that the study selection process was divided into two parts:

1. The systematic literature review on general disease characteristics, epidemiology, current treatment (standard of care) and burden of disease, including unmet needs.
2. The systematic literature review on health-related quality of life (HRQoL) studies, resource use and costs, clinical evidence, and economic evidence, according to NICE and Centre for Reviews and Dissemination (CRD) guidelines.

Table. Inclusion and Exclusion Criteria for the Selection of Clinical Studies (RCTs and non-RCTs)

Inclusion Criteria	Exclusion Criteria
<b>Population:</b>	
<ul style="list-style-type: none"> <li>Patients with VMT, including when associated with MH or ERM</li> </ul>	<ul style="list-style-type: none"> <li>Patients with other indication than VMT, including when associated with MH or ERM</li> </ul>
<b>Interventions:</b>	
<ul style="list-style-type: none"> <li>Ocriplasmin</li> <li>'Watch and wait'/standard of care</li> <li>Observation/standard of care</li> <li>Vitrectomy</li> </ul>	<ul style="list-style-type: none"> <li>Studies not evaluating ocriplasmin, 'watch and wait'/observation/standard of care or vitrectomy</li> </ul>
<b>Outcomes:</b>	
<ul style="list-style-type: none"> <li>Efficacy, safety, effectiveness</li> </ul>	<ul style="list-style-type: none"> <li>No outcome of efficacy, safety or effectiveness included</li> </ul>

Inclusion Criteria Study Design:	Exclusion Criteria
<ul style="list-style-type: none"> <li>Phase II, III and IV clinical studies or observational studies</li> <li>&gt;5 patients</li> <li>Studies that are not commentaries, letters to editors, or editorials</li> </ul>	<ul style="list-style-type: none"> <li>Not phase I, II, III and IV clinical studies or observational studies</li> <li>&lt;5 patients</li> <li>Commentaries, letters to editors, or editorials</li> </ul>
Language:	
<ul style="list-style-type: none"> <li>English, French, German, Spanish</li> </ul>	<ul style="list-style-type: none"> <li>Not English, French, German or Spanish</li> <li>Full text not published</li> </ul>

Abbreviations: ERM, epiretinal membrane; MH, macular hole; VMT, vitreomacular traction

The ERG considers the inclusion criteria to be mostly appropriate. With reference to the exclusion of non-English, French, German or Spanish language studies, the ERG considers that studies in any language and meeting the other inclusion criteria would be of relevance, but are unlikely to be a major omission.

### Cost-effectiveness

#### ERG Comment on Manufacturer's Review of Cost-effectiveness Evidence

The manufacturer carried out a systematic review of the literature to identify cost-effectiveness studies comparing ocriplasmin, 'watch and wait', or vitrectomy in patients with vitreomacular traction (VMT). The manufacturer excluded studies of people with macular hole (MH) or epiretinal membrane (ERM) without a diagnosis of VMT. The manufacturer searched the following databases: MEDLINE and EMBASE (Ovid); MEDLINE in-process (Ovid); the Cochrane library (Wiley); National Health Service Economic Evaluation Database (NHS EED), DARE, and HTA database (Centre for Reviews and Dissemination); and EconLit (EBSCO). The search was carried out in September 2012 and was restricted to English, French, German or Spanish language. No justification for limiting the studies to these languages was provided by the manufacturer.

After removing duplicates, the manufacturer identified a total of 268 citations. Following review of these citations, the manufacturer found that none of the identified studies were relevant and thus 'no health economic evaluation including patients with VMT was identified in the systematic review'. The ERG notes that the search terms used by the manufacturer were reasonable, and based on expert input and peripheral searches carried out, the ERG considers it unlikely that any relevant cost-effectiveness analyses have been excluded.

The ERG carried out a basic search of the literature and identified one cost-effectiveness study in people with MH without VMT. The ERG notes that, although not strictly relevant to the decision problem, this trial may be informative with respect to cost and quality of life of patients undergoing vitrectomy. A summary of this analysis is presented in Table 34 of the ERG report.

## Number of Source Documents

### Clinical Effectiveness

- Five randomised controlled trials (RCTs) were included.
- Three additional non-RCTs were also included.

### Cost-effectiveness

- No published health economic evaluations were identified.
- The manufacturer presented an economic model.

## Methods Used to Assess the Quality and Strength of the Evidence

### Expert Consensus

# Rating Scheme for the Strength of the Evidence

Not applicable

## Methods Used to Analyze the Evidence

Meta-Analysis of Randomized Controlled Trials

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

## Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Care Excellence (NICE) commissioned an independent academic centre to perform an assessment of the manufacturer's submission on the technology considered in this appraisal and prepare an Evidence Review Group (ERG). The ERG report for this technology appraisal was prepared by the BMJ Technology Assessment Group (BMJ-TAG) (see the "Availability of Companion Documents" field).

### Clinical Effectiveness

#### Quality Assessment

The manufacturer assessed two main randomised controlled trials (RCTs) TG-MV-006 and TG-MV-007 against criteria adapted from guidance for undertaking reviews in health care issued by the Centre for Reviews and Dissemination (CRD), as provided in NICE's template for manufacturer/sponsor submission of evidence to the Single Technology Appraisal (STA) process. The ERG independently validated the manufacturer's assessment; the manufacturer's assessment, together with accompanying minor comments from the ERG, is presented in Section 9.1 of the ERG report (see the "Availability of Companion Documents" field).

#### Description and Critique of Statistical Approach Used

The manufacturer's submission (MS) presents an overview of the statistical approaches used in the TG-MV-006 and TG-MV-007 trials. The analysis of the two studies was identical; both were analysed individually and as a pooled dataset. The pooling of the data was planned based on the similarity in design and data collection of the two studies. A masked medical review meeting was held to consider protocol violations, then the database was locked and unmasking was authorised. Where raw data from TG-MV-006 and TG-MV-007 have been considered together in the assessment of clinical effectiveness, this is referred to as "TG-MV-006 & 007 pooled".

The investigators calculated that a sample of 320 patients was required to detect a significant difference at 90% power for a two-sided alpha level of 0.05, if event rate of the primary outcome was 27.5% in the ocriplasmin group and 10.0% in the placebo group. Based on this calculation, a total of 326 participants were randomised in each study.

The manufacturer pre-specified four statistical analysis populations, and the flow of patients into each is presented in Section 9.2 of the ERG report. These sets were:

- Full analysis set
- Modified full analysis set
- Per-protocol set
- Safety set

The ERG considers the manufacturer's decision to use the intention to-treat dataset (full analysis set) for the primary analysis of clinical effectiveness to be appropriate.

For each categorical variable the data were summarised using group counts and percentages for each category. Fisher's exact test was used to detect differences between treatment groups and two sided 95% confidence intervals (95% CIs) for the difference between the two groups. Continuous variables were presented using summary statistics, and treatment groups were compared using the Wilcoxon rank-sum test.

A meta-analysis of data from TG-MV-006 and TG-MV-007 was conducted by the manufacturer in an attempt to "corroborate the validity of the integrated dataset", which the ERG validated using the data obtained at clarification. The meta-analysis used summary statistics from both trials

were used to synthesise the data into a single summary of effect, and heterogeneity between trials was assessed using Cochran's Q test and determination of the  $I^2$  statistic. A fixed effects and random effects models meta-analysis was performed using Comprehensive Meta-Analysis Version 2 to obtain Risk Difference effects and Risk Ratios with 95% confidence intervals.

See Section 4 of the ERG report for additional information on clinical effectiveness analysis (see the "Availability of Companion Documents" field).

### Cost-effectiveness

#### Summary and Critique of Manufacturer's Submitted Economic Evaluation by the ERG

The manufacturer developed a *de novo* economic model to evaluate the lifetime clinical and economic consequences of ocriplasmin (followed if necessary by vitrectomy) versus standard care in the treatment of vitreomacular traction (VMT), including when associated with a macular hole (MH) of  $\leq 400\mu\text{m}$ . Within the manufacturer's economic evaluation, standard care was defined as 'watch and wait' (followed if necessary by vitrectomy). The model was constructed in Microsoft® EXCEL and comprised short-term (represented with decision trees) and long-term (represented with a nested Markov model) components. The decision tree components of the model were used to assess the short-term (6 months) anatomical and visual outcomes captured in the pivotal Phase III ocriplasmin trials (TG-MV-006 and TG-MV-007). The nested Markov component of the model captured, in the long-term (6 months to lifetime), 'critical anatomical outcomes that determine VA [visual acuity], as well as those VA outcomes'. The ERG considers that the modelling approach taken by the manufacturer enabled important anatomical and visual outcomes to be simultaneously captured in the short- and long-term. In addition, the ERG notes that the manufacturer's model was transparent and generally accurate, although important details regarding pre-model data analysis were not reported in sufficient detail in the MS; however, relatively comprehensive details were provided at clarification.

#### NICE Reference Case Checklist

Tables 35 and 36 of the ERG report (see the "Availability of Companion Documents" field) summarise the ERG's assessment of the manufacturer's economic evaluation against the NICE reference case and Philips checklists, respectively.

#### Model Structure

The manufacturer's *de novo* economic model consists of short-term and long-term components, linked through a set of common health states and constructed using decision-tree and Markov frameworks, respectively. The manufacturer states that the purpose of the short-term component of the model is to track "patients through the first 6 months following diagnosis, based upon the clinical outcomes of the two pivotal Phase 3 trials". The aim of the long-term component of the model is reported to be to track patients over the remainder of their lifetimes. Overall, the manufacturer's model is constructed around three key structural assumptions:

1. A maximum of two vitrectomies are permitted per eye
2. VMT vitrectomy is always successful; however vitrectomies for MH may succeed or fail
3. No fellow eye involvement (FEI)

#### *Decision Tree Model Components*

The structure of the decision tree used to capture the short-term (6 month) outcomes varies slightly depending on the patient population considered; that is, according to whether patients have MH at baseline. Patients ERM status is not considered to affect the treatment pathway. Figures 3 and 4 of the ERG report display the short-term model structures used in patients with and without MH at baseline, respectively (see the "Availability of Companion Documents" field).

#### *Markov Model Components*

The short- and long-term components of the manufacturer's model are linked by a set of seven common disease health states (including the absorbing state of death), as follows:

- Resolved (i.e., no VMT or MH)
- VMT unresolved without MH
- VMT unresolved with MH
- VMT resolved with MH (0 vitrectomies)
- VMT resolved with MH (1 vitrectomy)
- VMT resolved with MH (2 vitrectomies)
- Dead

That is, the distribution of patients across these mutually exclusive disease health states at the end of the decision tree phase of the model, represent the starting distribution for patients moving into the long-term, Markov phase of the model. Figure 5 of the ERG report (see the "Availability of Companion Documents" field) displays the transitions between disease health states considered in the manufacturer's Markov model.

See Section 5 of the ERG report for more information on cost-effectiveness analysis (see the "Availability of Companion Documents" field).

## Methods Used to Formulate the Recommendations

Expert Consensus

## Description of Methods Used to Formulate the Recommendations

Considerations

Technology appraisal recommendations are based on a review of clinical and economic evidence.

Technology Appraisal Process

The National Institute for Health and Care Excellence (NICE) invites 'consultee' and 'commentator' organisations to take part in the appraisal process. Consultee organisations include national groups representing patients and carers, the bodies representing health professionals, and the manufacturers of the technology under review. Consultees are invited to submit evidence during the appraisal and to comment on the appraisal documents.

Commentator organisations include manufacturers of the products with which the technology is being compared, the National Health Service (NHS) Quality Improvement Scotland and research groups working in the area. They can comment on the evidence and other documents but are not asked to submit evidence themselves.

NICE then commissions an independent academic centre to review published evidence on the technology and prepare an 'assessment report'. Consultees and commentators are invited to comment on the report. The assessment report and the comments on it are then drawn together in a document called the evaluation report.

An independent Appraisal Committee then considers the evaluation report. It holds a meeting where it hears direct, spoken evidence from nominated clinical experts, patients and carers. The Committee uses all the evidence to make its first recommendations, in a document called the 'appraisal consultation document' (ACD). NICE sends all the consultees and commentators a copy of this document and posts it on the NICE Web site. Further comments are invited from everyone taking part.

When the Committee meets again it considers any comments submitted on the ACD; then it prepares its final recommendations in a document called the 'final appraisal determination' (FAD). This is submitted to NICE for approval.

Consultees have a chance to appeal against the final recommendations in the FAD. If there are no appeals, the final recommendations become the basis of the guidance that NICE issues.

Who Is on the Appraisal Committee?

NICE technology appraisal recommendations are prepared by an independent committee. This includes health professionals working in the NHS and people who are familiar with the issues affecting patients, and carers. Although the Appraisal Committee seeks the views of organisations representing health professionals, patients, carers, manufacturers and government, its advice is independent of any vested interest.

## Rating Scheme for the Strength of the Recommendations

Not applicable

## Cost Analysis

Summary of Appraisal Committee's Key Conclusions

## Availability and Nature of Evidence

The Committee considered the cost-effectiveness evidence presented in the manufacturer's submission, including the base-case incremental cost-effectiveness ratios (ICERs), the sensitivity and scenario analyses, as well as the Evidence Review Groups (ERG)'s critique of the manufacturer's evidence. The Committee understood that the modelling approach presented by the manufacturer was appropriate and that the assumptions and data sources were reasonable.

## Uncertainties Around and Plausibility of Assumptions and Inputs in the Economic Model

The Committee considered important areas of uncertainty in the model:

- The assumption that vitrectomy and cataract surgery would be completed separately, and that when the model accounted for combined surgery a disutility value to account for the addition of cataract removal to surgery was not added
- The cataract rate
- The macular hole (MH) vitrectomy success rate
- The metamorphopsia disutility value
- The number of optical coherence tomography and follow-up visits post-vitrectomy
- The retinal detachment and retinal tear rate
- The rate of visual decline not accounting for a MH

## Incorporation of Health-Related Quality-of-Life Benefits and Utility Values. Have Any Potential Significant and Substantial Health-Related Benefits Been Identified That Were Not Included in the Economic Model, and How Have They Been Considered?

The Committee agreed with clinical specialists that the ocriplasmin injection provided a step change in treating patients with vitreomacular traction (VMT) because it provides an alternative to 'watch and wait' and/or surgery. The Committee concluded that it was innovative. The Committee recognised that the benefit of this may not have been captured in the quality-adjusted life year (QALY) calculation.

## Are There Specific Groups of People for Whom the Technology Is Particularly Cost-Effective?

The Committee understood that there was not a group of people for whom ocriplasmin was particularly cost effective. However, it recognised that ocriplasmin was not clinically effective (in terms of total posterior vitreous detachment [PVD] and VMT resolution by day 28) for patients with VMT and epiretinal membrane (ERM), without a stage II MH. In addition, it concluded, taking into account the views of clinical specialists and the data from the VMT with ERM subgroup, that ocriplasmin was unlikely to be clinically effective (in terms of total PVD and VMT resolution by day 28) for patients with VMT, an ERM and a stage II MH. It therefore concluded that ocriplasmin was not cost effective for these groups.

## What Are the Key Drivers of Cost-Effectiveness?

For the VMT without ERM and VMT with ERM subgroups the model outcomes were most sensitive to the inputs determining non-surgical resolution of VMT at 6 months and 28 days. The QALY discount rate was also an important driver for these subgroups. For the VMT with MH subgroup, the model outcomes were most sensitive to the inputs that determined non-surgical MH closure, cataract disutility and the change of MH closure post-vitrectomy.

## Most Likely Cost-Effectiveness Estimate (Given as an ICER)

The Committee considered the use of ocriplasmin to treat VMT without an ERM or a stage II MH and concluded that the ICER was likely to be no greater than £20,900 per QALY gained (as presented by the ERG). It agreed therefore that ocriplasmin was a cost-effective use of National Health Service (NHS) resources for treating VMT in people without an ERM.

The Committee considered the use of ocriplasmin to treat VMT with an ERM but without a stage II MH and recognised that ocriplasmin was not clinically effective or cost effective for these people. The Committee therefore concluded that ocriplasmin could not be considered a cost-effective use of NHS resources for treating people with VMT and an ERM, without a stage II MH.

The Committee considered the use of ocriplasmin to treat VMT with a stage II MH. The Committee agreed that the preferred assumption was to include combined cataract and vitrectomy surgery, and noted the associated ICER was approximately £30,500 per QALY gained. The Committee also considered that addressing uncertainties in the model could both increase and decrease the ICER. The Committee recognised that ocriplasmin was unlikely to be clinically effective in patients who have an ERM and a stage II MH. Having taken into account all of the evidence submitted (from the manufacturer and the ERG), and comments received during consultation, the Committee concluded that on balance the ICER was likely to be lower than £30,500 per QALY gained and therefore ocriplasmin was a cost-effective use of NHS resources for treating people with VMT and a stage II MH without an ERM.

Refer to Sections 3 and 4 in the original guideline document for additional information on cost-effectiveness.

## Method of Guideline Validation

External Peer Review

## Description of Method of Guideline Validation

Consultee organisations from the following groups were invited to comment on the draft scope, Assessment Report and the Appraisal Consultation Document (ACD) and were provided with the opportunity to appeal against the Final Appraisal Determination.

- Manufacturer/sponsors
- Professional/specialist and patient/carer groups
- Commentator organisations (without the right of appeal)

In addition, individuals selected from clinical expert and patient advocate nominations from the professional/specialist and patient/carer groups were also invited to comment on the ACD.

## Evidence Supporting the Recommendations

### Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated for each recommendation.

The Appraisal Committee considered evidence submitted by the manufacturer of ocriplasmin and a review of this submission by the Evidence Review Group. The main clinical effectiveness evidence came from two randomised controlled trials. For cost-effectiveness, the Appraisal Committee considered an economic model submitted by the manufacturer.

## Benefits/Harms of Implementing the Guideline Recommendations

### Potential Benefits

Appropriate use of ocriplasmin for treating vitreomacular traction (VMT)

### Potential Harms

The summary of product characteristics lists the following adverse reactions for ocriplasmin: vitreous floaters, eye pain, photopsia, and conjunctival haemorrhage resulting from the injection procedure. Most of these reactions were non-serious, mild in intensity and resolved within 2 to 3 weeks.

For full details of adverse reactions and contraindications, see the summary of product characteristics.

## Contraindications

### Contraindications

For full details of adverse reactions and contraindications, see the summary of product characteristics.

# Qualifying Statements

## Qualifying Statements

- This guidance represents the views of the National Institute for Health and Care Excellence (NICE) and was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.
- Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

## Implementation of the Guideline

### Description of Implementation Strategy

- Section 7(6) of the National Institute for Health and Care Excellence (NICE) (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 requires clinical commissioning groups, National Health Service (NHS) England and, with respect to their public health functions, local authorities to comply with the recommendations in this appraisal within 3 months of its date of publication.
- When NICE recommends a treatment 'as an option', the NHS must make sure it is available within the period set out in the paragraph above. This means that, if a patient has vitreomacular traction and the doctor responsible for their care thinks that ocriplasmin is the right treatment, it should be available for use, in line with NICE's recommendations.
- NICE has developed a tool to help organisations put this guidance into practice (listed below). This is available on the [NICE Web site](#)  (see also the "Availability of Companion Documents" field):
  - Costing template and report to estimate the national and local savings and costs associated with implementation.

## Implementation Tools

Mobile Device Resources

Patient Resources

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

## Institute of Medicine (IOM) National Healthcare Quality Report Categories

### IOM Care Need

Getting Better

Living with Illness

### IOM Domain

Effectiveness

Patient-centeredness

## Identifying Information and Availability

### Bibliographic Source(s)

National Institute for Health and Care Excellence (NICE). Ocriclasmin for treating vitreomacular traction. London (UK): National Institute for Health and Care Excellence (NICE); 2013 Oct. 52 p. (Technology appraisal guidance; no. 297).

### Adaptation

Not applicable: The guideline was not adapted from another source.

### Date Released

2013 Oct

### Guideline Developer(s)

National Institute for Health and Care Excellence (NICE) - National Government Agency [Non-U.S.]

### Source(s) of Funding

National Institute for Health and Care Excellence (NICE)

### Guideline Committee

Appraisal Committee

### Composition of Group That Authored the Guideline

*Committee Members:* Professor Andrew Stevens (*Chair of Appraisal Committee C*), Professor of Public Health, University of Birmingham; Professor Eugene Milne (*Vice Chair of Appraisal Committee C*), Deputy Regional Director of Public Health, North East Strategic Health Authority, Newcastle upon Tyne; Professor Kathryn Abel, Director of Centre for Women's Mental Health, University of Manchester; Dr David Black, Medical Director, NHS South Yorkshire and Bassetlaw; Dr Daniele Bryden, Consultant in Intensive Care Medicine and Anaesthesia, Sheffield Teaching Hospitals NHS Trust; Dr Andrew Burnett, Formerly - Director for Health Improvement and Medical Director, NHS Barnet, London; David Chandler, Lay Member; Gail Coster, Advanced Practice Sonographer, Mid Yorkshire Hospitals NHS Trust; Professor Peter Crome, Honorary Professor, Dept of Primary Care and Population Health, University College London; Dr Maria Dyban, General Practitioner, Kings Road Surgery, Cardiff; Professor Rachel A Elliott, Lord Trent Professor of Medicines and Health, University of Nottingham; Dr Greg Fell, Consultant in Public Health, Bradford Metropolitan Borough Council; Dr Wasim Hanif, Consultant Physician and Honorary Senior Lecturer, University Hospital Birmingham; Dr Alan Haycox, Reader in Health Economics, University of Liverpool Management School; Dr Peter Jackson, Clinical Pharmacologist, University of Sheffield; Dr Janice Kohler, Senior Lecturer and Consultant in Paediatric Oncology, Southampton University Hospital Trust; Emily Lam, Lay Member; Dr Claire McKenna, Research Fellow in Health Economics, University of York; Professor Gary McVeigh, Professor of Cardiovascular Medicine, Queens University Belfast and Consultant Physician, Belfast City Hospital; Dr Grant MacLaine, Director, Health Economics and Outcomes Research, BD, Oxford; Dr Andrea Manca, Health Economist and Senior Research Fellow, University of York; Henry Marsh, Consultant Neurosurgeon, St George's Hospital, London; Dr Suzanne Martin, Reader in Health Sciences; Dr Paul Miller,

Director, Payer Evidence, AstraZeneca UK Ltd; Professor Stephen O'Brien, Professor of Haematology, Newcastle University; Dr Anna O'Neill, Deputy Head of Nursing and Healthcare School/Senior Clinical University Teacher, University of Glasgow; Alan Rigby, Academic Reader, University of Hull; Professor Peter Selby, Consultant Physician, Central Manchester University Hospitals NHS Foundation Trust; Dr Tim Stokes, Senior Clinical Lecturer, University of Birmingham; Dr Paul Tappenden, Reader in Health Economic Modelling, School of Health and Related Research, University of Sheffield; Dr Judith Wardle, Lay Member

## Financial Disclosures/Conflicts of Interest

Committee members are asked to declare any interests in the technology to be appraised. If it is considered there is a conflict of interest, the member is excluded from participating further in that appraisal.

## Guideline Status

This is the current release of the guideline.

## Guideline Availability

Electronic copies: Available from the [National Institute for Health and Care Excellence \(NICE\) Web site](#) .

## Availability of Companion Documents

The following are available:

- Edward SJ, Krause T, Trevor N, Lois N, Thurgar EJ, Barton S. Ocriplasmin for the treatment of vitreomacular traction. STA report. London (UK): BMJ Technology Assessment Group (BMJ-TAG); 2013. 241 p. Electronic copies: Available from the [National Institute for Health and Care Excellence \(NICE\) Web site](#) .
- Edward SJ, Krause T, Trevor N, Lois N, Thurgar EJ, Barton S. Ocriplasmin for the treatment of vitreomacular traction. STA report erratum. London (UK): BMJ Technology Assessment Group (BMJ-TAG); 2013. 37 p. Electronic copies: Available from the [NICE Web site](#) .
- Ocriplasmin for treating vitreomacular traction. Costing template. London (UK): National Institute for Health and Care Excellence (NICE); 2013 Oct. (Technology appraisal guidance; no. 297). Electronic copies: Available from the [NICE Web site](#) .

## Patient Resources

The following is available:

- Ocriplasmin for vitreomacular traction. Information for the public. London (UK): National Institute for Health and Care Excellence (NICE); 2013 Oct. (Technology appraisal guidance; no. 297). Electronic copies: Available from the [National Institute for Health and Care \(NICE\) Excellence Web site](#) . Also available for download as a Kindle or EPUB ebook from the [NICE Web site](#) .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

## NGC Status

This NGC summary was completed by ECRI Institute on January 24, 2014.

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